

1  
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

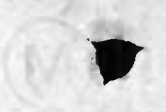
VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02315

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Clements</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>William H. Armstrong</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>1,</b> Year <b>19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June July 7, 1961</b>	
9. AGE (In years last birthday) yrs. <b>7</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Armstrong</b>				14. MOTHER'S MAIDEN NAME <b>Margie Armstrong Herbert</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Margie Armstrong Clements, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>7720</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 days since birth</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William D. Boyd M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>2/5/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/3/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Morganza, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>W. Clarke Mattingley Leonardtown, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 7 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

4100203182

THE STATE OF MARYLAND



John W. Davis  
Governor

James H. Smith  
Lieutenant Governor

William H. Davis  
Comptroller

John W. Davis  
Attorney General

John W. Davis

James H. Smith

William H. Davis

John W. Davis

James H. Smith

William H. Davis

John W. Davis

James H. Smith

William H. Davis

John W. Davis

John W. Davis

James H. Smith

William H. Davis

John W. Davis

James H. Smith

John W. Davis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02334

02316

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		d. STREET ADDRESS <b>Rural</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Perry</b> Last <b>Barnes</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>19 62</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Augusta Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Julia Dean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Mrs. Berhice Talton - Ridge, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Influenza</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 days</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>H ASKVD</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1961</b> to <b>2/10 1962</b> that (I) (we) last saw the deceased alive on <b>2/10 1962</b> and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James P. Jarboe, MD</b>		22b. DATE SIGNED <b>2/10/62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Great Mills, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Ridge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 13 '62</b>	
		25b. REGISTRAR'S SIGNATURE <b>C. L. H. H.</b>	

US 117

CERTIFICATE OF DEATH

100332

(M)

NAME

NAME

RESIDENCE

RESIDENCE

ST. MARYS HOSPITAL

ST. MARYS HOSPITAL

DATE

DATE

SEX

SEX

CAUSE

CAUSE

DIAGNOSIS

DIAGNOSIS

NO

NO

Copyright - 1917  
Copyright - 1917

Copyright - 1917  
Copyright - 1917

James E. Carson, MD  
St. Marys Hospital

St. Marys Hospital

St. Marys Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 11 Film G308 3/1/62 iwk

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtoun</b> c. LENGTH OF STAY IN lb <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD 1 Mechanicsville,</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>El1 G. Brubacher</b>		4. DATE OF DEATH Month Day Year <b>February 17, 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1915</b>
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Michigan</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Brubacher</b>		14. MOTHER'S MAIDEN NAME <b>Katie Gehmen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-32-0188</b>	
17. INFORMANT <b>Mrs Priscilla W. Brubacher</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>	
22b. DATE SIGNED <b>Feb 18, 1962</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>Feb 17, 1962</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>3:30 P</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W. H. Patrick</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>William H. Patrick M. D.</b>		22d. ADDRESS <b>Lexington Park, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/21/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Armish Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Loveville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtoun, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

(M)

(T)

08333

08333

St. Mary's Hospital

St. Mary's Hospital

St. Mary's Hospital

St. Mary's Hospital

St. Mary's Hospital

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St. Mary's Hospital

St. Mary's Hospital

St. Mary's Hospital



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02319											
Item 4 Film G308 3/6/62 mh											
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Loveville</b>				c. LENGTH OF STAY IN lb <b>15 years</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Loveville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John F. Brubacher</b>				4. DATE OF DEATH <b>February 24, 1962</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 5, 1941</b>		9. AGE (in years) <b>21</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Enoch H. Brubacher</b>				14. MOTHER'S MAIDEN NAME <b>Catherine S. Fox</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Father</b>		Address <b>same as # 2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injury of chest</b> <b>830X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car fell off jack while deceased was underneath.</b>							
20c. TIME OF INJURY Hour <b>5:00 p.m.</b> <b>2:24</b> <b>1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>farm</b>		20f. (City or town) <b>Loveville</b>		20g. (County) <b>St Marys</b>		20h. (State) <b>Med</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>William D. Boyd</b>				M.D. <b>William D. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/28/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Amish Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Loveville, Maryland</b>			
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b>						ADDRESS <b>Leonardtown, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 2 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

YOU WILL  
RECEIVE



1933

1933

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

ST. LOUIS

Maryland

St. Louis

St. Louis

St. Louis

15 years

Joint

St. Louis

White

St. Louis

St. Louis

St. Louis

St. Louis

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St. Louis

St. Louis



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02337 CERTIFICATE OF DEATH 02320

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Valley Lee Rural</b> c. LENGTH OF STAY IN life <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Valley Lee</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sarah Magdalene Coates</b>		4. DATE OF DEATH Month Day Year <b>February 6, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1901</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hauling</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George R. Watts</b>		14. MOTHER'S MAIDEN NAME <b>Rosette Greenwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>220-32-5744</b>	
17. INFORMANT <b>Mrs James Bean</b>		Address <b>Valley Lee, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Ventricular Fibrillation</b> <b>Myocardial Infarction</b> <b>HAS CVD</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peptic Ulcers</b> INTERVAL BETWEEN ONSET AND DEATH <b>men</b> <b>min.</b> <b>yes</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 1961</b> to <b>2/6/62</b> that (I) (we) last saw the deceased alive on <b>3/6/62</b> and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James B. Jarboe</b>		22b. DATE SIGNED <b>2/7/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Patrick Jarboe M.D.</b>		22d. ADDRESS <b>Great Mills, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/9/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. George Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Valley Lee, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>	
ADDRESS <b>Leonardtwn, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

03.20

03837

St. Mary's

Valley Lee

St. Mary's

Valley Lee

St. Mary's

Valley Lee

St. Mary's

Valley Lee

03

February 6

George

Washington

St. Mary's

00

August 19, 1913

A

White

Female

U.S.A.

Washington

Working

Hauling

George A. White

George A. White

Valley Lee, Maryland

Geo. A. White, Jr.

*Handwritten notes:*  
Ventura, California  
Pyramidal region  
A 48010

*Handwritten:* Purple Wren

George A. White

George A. White

Maryland

Valley Lee

St. George Cemetery

2/21/13

St. Mary's

St. George Cemetery, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02338 CERTIFICATE OF DEATH 02321

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>	
c. LENGTH OF STAY IN lb <b>5 hrs</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Benedict Drury Duke</b>		4. DATE OF DEATH <b>February 1, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1918</b>
9. AGE (In years last birthday) <b>43 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>43</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker &amp; Realtor</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roland Benjamin Duke</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Drury</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-12-0696</b>	
17. INFORMANT <b>Virginia B. Duke</b>		Address <b>Leonardtwn, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>237X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1952</b> to <b>Feb 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb 1962</b> and that death occurred at <b>11</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Roy Guyther</b>		22b. DATE SIGNED <b>Feb 7 '62</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Roy Guyther M.D.</b>		22d. ADDRESS <b>Mechanicsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Chapel</b>		23d. LOCATION (City, town or county) (State) <b>Medley's Neck, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>FEB 7 '62</b>	
ADDRESS <b>Leonardtwn, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

15353

02388



St. Mary's

Maryland

St. Mary's

Leominster

St. Mary's

Leominster

St. Mary's Hospital

Leominster

St. Mary's

Leominster

St. Mary's

60

St. Mary's

Leominster

St. Mary's

Brother's Hospital

Maryland

U.S.A.

Leominster Hospital

William Henry

Leominster, Maryland

Virginia S. Duke

218-12-000

No

*Handwritten signature*

St. Mary's Hospital

Leominster, Maryland

Leominster

St. Mary's Hospital

Leominster, Maryland

St. Mary's Hospital, Leominster, Maryland

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02339 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02322											
Item 3 Film G307 2/19/62 iwk											
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Great Mills,</b>						c. LENGTH OF STAY IN lb <b>20 years</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS <b>Rural Great Mills</b>					
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Edison</b> Last <b>Edison</b>						4. DATE OF DEATH Month <b>February</b> Day <b>1,</b> Year <b>19 62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 25, 1903</b>		9. AGE (In years last birthday) <b>58 ?</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>? ?</b>				14. MOTHER'S MAIDEN NAME <b>? ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Edison</b> <b>George Edgiston</b> Address <b>Great Mills, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia, lower lobes, bilateral</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cardiac hypertrophy, moderate</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Heart</b> causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>February 2, 1962</b>											
ACTUAL SIGNATURE <b>Rudiger Breitenecker, M.D.</b>				EXAMINER'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>				Address (Street, city, town, or county) <b>February 2, 1962</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/6/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Great Mills, Maryland</b>			
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b> Leonardtown, Md.						24a. REC'D BY REGISTRAR DATE <b>FEB 7 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

RECEIVED  
FEB 21 1962



Internal Affairs, Bureau

20 years

Serial

Great Mills

Agency

Alfred Nelson

February 1, 1962

Police

Unlabeled

Nov 27, 1961

High School

None

Arresting

no

none

George S. Nelson

Great Mills, Maryland

Serial 2/6/62 Holy Face Cemetery Great Mills, Maryland

Internal Affairs, Bureau



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																								
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																								
02340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02323																								
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Piney Point</b>					c. LENGTH OF STAY IN 1b <b>Life</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Piney Point</b>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <b>1</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <b>Lillian Ann Goddard</b>					4. DATE OF DEATH Month <b>Feb.</b> Day <b>24</b> Year <b>1962</b>																			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1962</b>		9. AGE (In years last birthday) <b>19</b> yrs.		IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.		IF UNDER 24 HRS.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>George E. Goddard</b>					14. MOTHER'S MAIDEN NAME <b>Ethel G. Adams</b>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Mother same as # a above</b>					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>763.0</b> <b>Bronchial pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>763.0</b> <b>Bronchial pneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE <b>William D. Boyd M.D.</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>															DATE SIGNED <b>2/24/62</b>									
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>															Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>2/25/62</b>					22c. NAME OF CEMETERY OR CREMATORY <b>St. George Cemetery</b>					22d. LOCATION (City, town, or country) (State) <b>Valley Lee, Maryland</b>									
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b> ADDRESS <b>Leonardtwn, Maryland</b>										24a. REC'D BY REGISTRAR <b>FEB 27 '62</b> DATE					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>									

VS. A15ME  
5M 7/59

2078323185

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MAY 1951



Dr. Mary

Miss Mary

Miss

Miss

Miss

William

Miss

Miss

Feb. 5, 1952

Miss

Miss

Miss

Miss

George E. Goddard

George E. Goddard

Robert E. Goddard

Robert E. Goddard

Miss

Miss

Miss

Miss

Miss

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02341

02324

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Clements</b> c. LENGTH OF STAY IN 1b <b>52 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Clements</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Agnes Abell Guy</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>February 17, 19 62</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 7, 1887</b>	
<b>9. AGE</b> (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Wife &amp; Merchant</b>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Perry Abell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Fulton</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mrs Claudia Yates Clements, Maryland</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Head of Pancreas</b> DUE TO (b) <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>April 1, 1961</b> <b>to</b> <b>Feb. 17, 1962</b> <b>that (I) (the) last saw the deceased alive on</b> <b>Feb. 17, 1962</b> <b>and that death occurred at</b> <b>7 PM</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>W.H. Patrick M.D.</b>				<b>22b. DATE SIGNED</b> <b>2-18-62</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>William H. Patrick M. D.</b>	
<b>22d. ADDRESS</b> <b>Lexington Park, Maryland</b>				<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			
<b>23b. DATE THEREOF</b> <b>Feb. 20, 1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Josephs Cemetery</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Morganza, Maryland</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Clarke Mattingley</b>	
<b>24. FUNERAL DIRECTOR'S ADDRESS</b> <b>Leonardtwn, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 23 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02321

St. Mary's

Clergy

25 years

Clergy

St. Mary's

St. Mary's

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Abell

day

February 11

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Female

White

Sept. 7, 1887

74

James W. & Margaret

St. Mary's

U. S. A.

Perry Abell

Baron Wilton

St. Mary's, Maryland

2 30107

William H. Patrick M. D.

Lexington Park, Maryland

Burial

Feb. 20, 1902

St. Joseph's Cemetery

Hagerman

Maryland

St. Charles Catholic Church, Hagerman, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02342					02325						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		St. Mary's			a. STATE		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Leonardtown			b. COUNTY		St. Mary's				
c. LENGTH OF STAY IN lb		9 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Rural Avenue				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
St. Mary's Hospital					1						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
First		Middle		Last		Month		Day			
Spencer		Ignatius		Hayden		Feb.		23			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs. Months Days			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 27, 1886		75 yrs. 23 19 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Farming							Maryland		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
William Abell Hayden					Selina Downs						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT				
no							Ann W. Hayden				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					Address						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)					Hemorrhage						
451X DUE TO					Ruptured aortic aneurysm						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					Generalized arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					Fractured right hip.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED						
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from 2-18-1962 to 2-23-1962 and that death occurred at 2-23-1962 and that death occurred at 2-23-1962, from the causes and on the date stated above.					21b. DATE SIGNED						
22a. SIGNATURE					22b. DATE SIGNED						
A. Samadi					M.D.						
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
A. Samadi M. D.					Leonardtown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial					Feb. 26, 1962		St. Aloysius		Leonardtown, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS					25a. REC'D BY REGISTRAR	
W. Clarke Mattingley					Leonardtown, Maryland					DATE MAR 5 '62	
										25b. REGISTRAR'S SIGNATURE	
										Arthur L. Kross	

02029

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Maryland

St. Mary's

Funeral Avenue

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Leontopolis

B. Mary's Hospital

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July 27, 1936

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Maryland U.S.A.

Towing

Bellevue House

William Adolf Hayden

no

John A. Hayden

Avenue, Maryland

Leontopolis, Maryland

A. James, M.D.

Leontopolis

St. Mary's

Feb. 26, 1936

Serial

St. Mary's Hospital, Leontopolis, Maryland



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 02343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02326

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>St. Mary's</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Park Hall</b>			c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Rural</b> <b>Park Hall</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Andrew</b> Middle <b>Jackson</b> Last <b>Hill</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>24</b> , Year <b>19 62</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Oct. 9, 1884</b>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Harrison Hill</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Louise ??</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> Address <b>Mrs Julia D. Courtney RFB 343 Lexington Park,</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CV accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CA of Stomach</b> DUE TO (c)							<b>ONSET AND DEATH</b> <b>27 hrs</b> <b>3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <i>William D. Boyd</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>William D. Boyd M.D.</b>				<b>DATE SIGNED</b> <b>2/24/62</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>2/27/62</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Zion Church Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Lexington Park, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>W. Clarke Mattingley Leonardtown, Maryland</b>				<b>24a. REC'D BY REGISTRAR</b> <b>FEB 27 '62</b>		<b>24b. REGISTRAR'S SIGNATURE</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02344

02327

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>X</b> Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>ANGELINE</b> Last <b>HILL</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 62</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George G. Hill</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Cullison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT Address <b>Mrs. Alma Ellis - Oakley, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Interwooderotic CV disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>15 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured hip - fall</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 48</b> to <b>Feb 24</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Feb 24</b> 19 <b>62</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. Roy Guyther</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/24/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Roy Guyther, MD</b>				22d. ADDRESS <b>Mechanicsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/27/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Bushwood, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson</b>				25a. REC'D BY REGISTRAR <b>FEB 28 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Plante</b>	

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02384

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02345

02328

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN lb <b>6 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Piney Point</b>	
		d. STREET ADDRESS <b>1</b>	
		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Vernette Johnson</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>19</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 4, 1911</b>
<b>9. AGE</b> (In years last birthday) <b>50</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	
<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U.S.A.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Joseph Jones</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Essie Brown</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>no</b>	
<b>17. INFORMANT</b> <b>Charles N. Johnson</b>		<b>Address</b> <b>Piney Point, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year (3)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Feb 12, 1962</b> <b>to</b> <b>Feb 19, 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Feb 18, 1962</b> <b>and that death occurred at</b> <b>2:20 AM</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>P. J. Bean M. D.</b>		<b>22b. DATE SIGNED</b> <b>2/20/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>P. J. Bean M. D.</b>		<b>22d. ADDRESS</b> <b>Great Mills, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/22/62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Mark's Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Valley Lee, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Clarke Mattingley</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>	
<b>ADDRESS</b> <b>Leonardtwn, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 26 '62</b>	

02333

02333



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02329

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ERNAH [REDACTED] GRACE [REDACTED] KNIGHT</b>		4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>19 62</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1881</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Amos Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Waterworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Marie Winchester - Washington, D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 4924 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>pneumonitis and chronic pulmonary fibrosis</b> DUE TO (c) <b>8 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>seizure</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1 1961</b> to <b>Feb 25 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 25 1962</b> and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Julian S. Lane</b>		22b. DATE SIGNED <b>2/26/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Julian S. Lane</b>		22d. ADDRESS <b>Lexington Park, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/28/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrews Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson</b>		25a. REC'D BY REGISTRAR <b>FEB 28 '62</b>	
ADDRESS <b>P.B. Robinson - Leonardtown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Caroline S. Thoma</b>	

(12/25)

CERTIFICATE OF DEATH

12/25/25

12/25/25

M

1. Name of deceased: John Doe  
2. Sex: Male  
3. Age: 45  
4. Date of birth: Nov 15, 1910  
5. Place of birth: St. Louis, Mo.  
6. Usual residence: 123 Main St., St. Louis, Mo.  
7. Cause of death: Heart disease  
8. Date of death: Dec 25, 1925  
9. Place of death: St. Louis, Mo.  
10. Signature of physician: [Signature]  
11. Signature of registrar: [Signature]  
12. Signature of undertaker: [Signature]

*[Faint, illegible handwritten text, possibly a continuation of the certificate or a separate note.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02347 CERTIFICATE OF DEATH 02330									
1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Loveville</b>			c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Loveville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Francis Irving Long</b>			First Middle Last		4. DATE OF DEATH <b>February 15, 1962</b>		Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1892</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Robert Long</b>					14. MOTHER'S MAIDEN NAME <b>Catherine Ann Johnson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Eunice A. Long Loveville, Maryland</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>few min.</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8/31</b> , 19 <b>61</b> , to <b>Apr 61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Apr 27 61</b> , 19 <b>61</b> , and that death occurred at <b>8/31</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>J. Roy Guyther</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>J. Roy Guyther M. D.</b>					22d. ADDRESS <b>Mechanicsville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 19, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Morganza, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>					25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02348					02332						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		St. Mary's			a. STATE		b. COUNTY				
		MARYLAND			Maryland		St. Mary's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
Leonardtwn			10 days		X Clements						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
St. Mary's Hospital											
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH			
Bessie		G.		McWilliams		February 21,		19 62			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR			
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 12, 1870		91 yrs.		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
House wife			Home		Maryland			U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
James B. Garson					Mary E. Maddox						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT						
No			None		George McWilliams Jr Clements, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										1 month	
422.1 DUE TO										2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										10 years	
DUE TO											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(State)		
Month, Day, Year			While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>								
Hour a.m. p.m.											
19											
21. I certify that (I) (this hospital) attended the deceased from Jan 1957 to Feb 21 1962 that (I) (we) last saw the deceased alive on Feb 21 1962 and that death occurred at 8:15 PM from the causes and on the date stated above.											
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
W H Patrick					M.D.			2-22-62			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
William H. Patrick M. D.					Lexington Park, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)		
Burial			2/24/62		Sacred Heart Cemetery		Bushwood,		Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. Clarke Mattingley					Leonardtwn, Maryland		DATE FEB 27 '62		Cuthbert S. Thomas		

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Aug. 12, 1870

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Box 1

James H. Carson

Maryland

Home

Home

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*Washington*  
*Washington*

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02349

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02333

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Scotland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>			d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Augusta</b> Last <b>Norris</b>			4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>19 62</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1878</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William Franklin Norris</b>		
14. MOTHER'S MAIDEN NAME <b>Alice Dyer</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Lloyd E. Norris Scotland, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Fractured hips</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on stairway</b>			
20c. TIME OF INJURY Hour <b>7:45 p.m.</b> Month, Day, Year <b>2-8-62</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Washington</b>	(County) <b>DC</b>	(State) <b>DC</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Wm D Boyd</b>		M.D. <b>William D. Boyd M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 3, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>	
22d. LOCATION (City, town, or country) <b>St. Mary's City, Md.</b>		22e. LOCATION (City, town, or country) (State) <b>St. Mary's City, Md.</b>			
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		DATE SIGNED <b>3/2/62</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02350

## CERTIFICATE OF DEATH

02334

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural California</b>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Ann Pingleton</b>		d. STREET ADDRESS <b>1</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 24, 1880</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bedford Clark</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Grant</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Joseph Pingleton Abell, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic CV disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> , 19 <b>61</b> , to <b>2/4</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>2/10</b> , 19 <b>62</b> ; and that death occurred at <b>11</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Joy L. Mattingley</b>		22b. DATE SIGNED <b>2/13/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.D.</b>		22d. ADDRESS <b>Mechanicsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/7/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Joy Chapel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hollywood, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>	
ADDRESS <b>Leonardtwn, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

08330

08330

M

A

St. Mary's  
12 days  
Hospital

St. Mary's Hospital  
June 24, 1960  
White  
Home wife  
Bedford Clark  
Rabson Grant

Joseph Pinigton  
Abell, Maryland

*[Faint handwritten text]*

*[Faint handwritten text]*

W. Clark Institute  
Joy Chapel Cemetery  
Hollywood, Maryland  
Nottingham, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02351

02335

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b> c. LENGTH OF STAY IN lb <b>1 hr</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Mary's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Maddox</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Russell</b> Last <b>Russell</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>22,</b> Year <b>19 62</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 4, 1875</b>	
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Woodburn</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Burroughs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>422,1</b>	
17. INFORMANT <b>Walter Goode</b>		Address <b>Maddox, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <b>Pneumonia, hypostatic</b> (b) <b>Arteriosclerotic changes, cardiac decompensation</b> (c) <b>422,1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 d.</b> <b>10 7 m</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1962</b> to <b>Jul 22, 1962</b> that (I) (we) last saw the deceased alive on <b>Jul 22, 1962</b> and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Roy Guyther</b>		22b. DATE SIGNED <b>Jul 22, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. ROY GUYTHER M. D.</b>		22d. ADDRESS <b>Mechanicsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION (City, town or county) (State) <b>Bushwood, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Maryland</b>	
25a. REC'D BY REGISTRAR <b>FEB 27 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

W. Charles Hastingley, Leesport, Maryland

Serial

140602

Edward Henry

Leesport, Md.

Leesport, Md.

J. M. CUYLER, JR.

*[Handwritten signature]*

*[Handwritten signature]*

*[Handwritten signature]*

*[Handwritten signature]*

Leesport, Md.

Leesport, Md.

Leesport, Md.

Leesport, Md.

House wife

Leesport, Md.

Female White

Leesport, Md.

Leesport, Md.

Leesport, Md.

St. Mary's Hospital

Leesport, Md.

Leesport, Md.

Leesport, Md.

Leesport, Md.

Leesport, Md.

Leesport, Md.

02333

CERTIFICATE OF DEATH

02333





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>																																																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>												c. LENGTH OF STAY IN 1b <b>Unknown</b>												c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>												d. STREET ADDRESS <b>307 Sewanee Place</b>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Station Hospital, USNAS</b>																																																															
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>PATRICIA</b> Last <b>SIMMERER</b>												4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>19 62</b>																																																			
5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>14 March 1924</b>				9. AGE (In years last birthday) <b>37</b> yrs.				IF UNDER 1 YEAR Months <b></b> Days <b></b>				IF UNDER 24 HRS. Hours <b></b> Min. <b></b>																																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>												10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>												11. BIRTHPLACE (State or foreign country) <b>New York</b>												12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																											
13. FATHER'S NAME <b>Edward Clark</b>												14. MOTHER'S MAIDEN NAME <b>Mary Murphy</b>																																																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>												16. SOCIAL SECURITY NO. <b></b>												17. INFORMANT <b>Hospital Records</b>												Address <b>St. Mary's County Sheriff</b>												Maryland															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Alcoholism</b> DUE TO (b) <b></b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b></b> DUE TO (c) <b></b>																																																INTERVAL BETWEEN ONSET AND DEATH <b></b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																																																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b></b>												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>																																																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>												20f. (City or town) (County) (State) <b></b>																											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.												CHIEF MEDICAL EXAMINER <input type="checkbox"/>												ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>												DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED <b>2/8/62</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>												Address (Street, city, town, or county) <b></b>																																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>												22b. DATE THEREOF <b>2/13/62</b>												22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>												22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>																											
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b>												ADDRESS <b>Leonardtown, Maryland</b>												24a. REC'D BY REGISTRAR <b>Feb 13 '62</b>												24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>																											



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02338

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Colton Point</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Rural Colton Point</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Roland</b> Last <b>Woodland</b>				4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 22, 1915</b>		9. AGE (In years last birthday) <b>46 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Francis Young</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ella Woodland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Ella Woodland Colton Point, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary infarct</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe scoliosis ( Thoracic )</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William D. Boyd</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>William D. Boyd M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>2/12/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/14/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Elarke Mattingley</b>				ADDRESS <b>Leonardtwn, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 14 '62</b>	
				24b. REGISTRAR'S SIGNATURE <i>William D. Boyd</i>			

(M)

(I)

MEDICAL CERTIFICATION

